Written comments submitted to the Department of Health Care Services (DHCS) regarding the transfer of Medi-Cal related specialty mental health functions to DHCS

Comments received July 18 through July 21, 2011

Note: in some cases, DHCS has edited the responses to explain the acronym used by the writer.

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1. **What are your comments on the organizational placement of mental health functions and mental health leadership within DHCS?**

   As a staff member of a local mental health plan, I am in support of the placement of a Behavioral Health Deputy Director in the DHCS leadership structure. I would strongly encourage you to have this position report to Director long term, but most importantly during the transition.
   The ideal individual for this position will be an individual with vision, who understands both Mental Health and Alcohol and Drug state structures as well as the DHCS structure and how to make change within those structures in a cost neutral way, for the betterment of current services and the strategic planning of future services. We will still need a behavioral health advocate but we will just as strongly need a health strategist in this position. This leader must know how to lead and love leading during large structural changes such as this—communication will be key to every aspect of this transition. To hope for no disruption in service is the goal, and this deputy will need to effectively communicate amidst tremendous ambiguity and change to widespread consumers and stakeholders, each providing services in vastly different operating environments.
   Status quo is no longer a reality and excellent leadership and negotiation skills to convince others of necessary, beneficial change while maintaining a strong behavioral health culture during that change will need to be an organizational priority. We need someone who will lead us to the new way of providing services, in partnership and collaboration with other service providers, someone who can break down old institutional barriers, and we are depending on you to make the right choice in selecting that leader, not only for the counties, but for all the beneficiaries receiving needed behavioral health services.

2. **What are your recommendations regarding the role of stakeholders and interaction between stakeholders and:**

   a. **DMH and DHCS during the transfer period, and**

      I would strongly encourage DHCS staff to take the suggestions of consumers "pre-meetings," before larger meetings. This will assist consumers with meaningful participation in the larger meetings. I would also ask you to consider the "Sacramento effect," which is the representation of mostly local Sacramento folks at your Sacramento meetings. Please do take the time to hold regional meetings as stakeholders all over the state need a change to attend in person. Attending in person is a much different experience that phoning in. While the Sacramento stakeholders are passionate and valued, there are thousands of stakeholders all over the state with value insight and expertise that would add to this process. [clipped text - writer offers to assist and provides contact information]

   b. **DHCS on an on-going basis.**

      Once you have a clear organizational structure, we would ask you to work with the California Mental Health Director's Association (CMHDA) to establish a clear stakeholder communication plan, including identifying meetings in which regular communication can occur. Also, we would ask you to consider a venue for both Mental Health and Alcohol and Drug Stakeholders to come together—We would suggest that this venue would only be established once a clear vision for the two

departments had been established and that the intent would be to look at joint issues, future planning needs and specific partnership opportunities.

3. **How can DHCS and DMH ensure continued access and quality services pre and post transfer, with no service interruption to beneficiaries and providers?**

Communication will be key! Clearly outlining what changes are to be made, and communicating those changes with clear instructions in writing will be integral to the maintenance of quality services. Providers and mental health plans (MHP) will follow directions if they are clear and concise. Also, if possible, it would be great to put out a communication brief explaining the types of communication tools DHCS utilizes and how information will be disseminated. Many of us are working with DHCS as new partners and we would like to be educated by DHCS as to their communication tools and style. Also, in matters of communication, at least until we get to know each other better, a definition of terms would be greatly appreciated when communicating instructions and terms. Please do not assume that we all have the same meanings for words we are all using!

Also, as mentioned at the meeting, counties don't just think of clients as, "Medi-Cal," only as many different funding sources, realignment, Mental Health Services Act (MHSA), Managed Care are used as match in county systems. A list of those functions that DHCS considers to me "Non-Medi-Cal," would be greatly helpful as we define our organizational relationships with DHCS. Additionally, DHCS's communication with MHP's and stakeholders about whom and what will be overseeing the, "Non Medi-Cal," functions is essential. We know DMH will be leading the efforts on those duties, but coordination and effective communication between the two departments and out to all of us will be essential!!!

4. **What changes and efficiencies do you think the departments should consider in this initial phase of the Medi-Cal related mental health transfer to DHCS? What is the fiscal and programmatic impact?**

Good communication to begin with, will create efficiencies right away. Also, a better understanding of what "activities," DHCS will take on will help inform what suggestions can be given to DHCS on efficiencies. Once you share the list of activities (versus duties) I think you will get very concrete suggestions.

5. **Considering the above questions, what are your priorities for discussion in future meetings?**

A definition of what activities will be coming to DHCS.

- Definition of "Non-Medi-Cal," activities and or duties that will not be managed by DHCS.

- Discussion of those gray area duties that cut across all populations like cultural competency and DHCS's interaction with those duties for Medi-Cal beneficiaries.
  Discussion of this division of DHCS with 1115 Waiver activities and identification of what activities will impact County MHP's from DHCS's perspective over the next two-five years. I.E, Low Income Health Program, State-wide Behavioral Health Assessment as well as your divisions role in those activities.

- Discussion of this division of DHCS and the 1915b waiver and it's interaction with larger waivers, as well as the two year deadline.

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- County MHP contracts with DHCS as MHPs'.

- Status of External Quality Review Organization (EQRO).

Also, please consider the current "layered and bifurcated," status of Mental Health funding. This creates layered bifurcated systems. A single state agency with oversight of all behavioral health funding sources would be ideal—This would take quite a legislative clean up, but a reconceptualizing of service delivery structures (county and state) is due and in the long run would save money (Maintaining budget neutrality). This would include looking at the state rate and claiming structures for specialty mental health services, alcohol and drug services, primary care related behavioral health, primary care and combining them under one state plan (Dare I say it, but let's not also forget FQHC's in this analysis! Totally different animals but part of the mix). Think Kaiser Permanente—yes, we are different than Kaiser, but the Kaiser Permanente model philosophically is what we are thinking of here. All services available under one organizational umbrella, with that organizational umbrella ensuring that all services under the state plan are provided under that umbrella per that umbrella's contract with the single state agency administering the state plan. Years of work, yes? But worth it, yes! Please consider this as a long term strategy as the time has come and the systems, plans and structures created by past/current public health policy are in need of evolution!

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Comment Period
We appreciated the well-run community stakeholder meeting held on July 12, 2011, and the carefully prepared background materials and useful information conveyed. However, two days to submit comments is inadequate, a minimum of one week should be adopted as a standard.

Non Medi-Cal Services
It is unfortunate that the non Medi-Cal mental health functions of the Department of Mental Health are being considered in a separate stakeholder process. We suggest that deliberate steps be taken to link these efforts and ultimately integrate them.

Specifically, we suggest that a crosswalk be developed that lays out all transition issues, and then notes where they are being handled and outlines efforts to align them, with the goal of bringing all mental health programs into integrated oversight, administration and quality improvement.

Olmstead Implementation
We are concerned about the non Medi-Cal-funded Skilled Nursing Homes designated as "Institutions for Mental Disease." These institutional settings are inconsistent with the requirements of the Supreme Court's Olmstead decision and the Americans with Disabilities Act. We suggest that part of this process includes planning for the provision of services and supports through specialty Medi-Cal to current residents of IMD's who should be moved and served in non-institutional community settings.

We request that any plan developed include a specific written analysis of how it complies with and advances the Supreme Court's Olmstead decision.

California Community Transitions
Consistent with this recommendation, we suggest that residents of Skilled Nursing Facilities designated as "Institutions for Mental Disease" be given greater emphasis and planning under the California Community Transitions Program, the state's Money Follows the Person Rebalancing Demonstration.

Multicultural Affairs
Along with others who attended the meeting, we are concerned about the fate of the Department of Mental Health Office of Multicultural Affairs. We believe that the work of the Office of Multicultural Affairs is very important and needs to be continued at a high level within the Department of Healthcare Services. However, in its previous work this office has not adequately addressed the needs of people with multiple disabilities, i.e. physical or other non-mental health disability and a mental health disability, as an underserved population. The cross-disability community has extensive unmet mental health needs and should be fully addressed, along with other underserved communities, by the Office of Multicultural Affairs.

Revenue Maximization
In the past, the Department of Healthcare Services has given inadequate attention to the development of federal revenue maximization and application for waivers to serve people with mental health disabilities. This consolidation of functions provides the opportunity to strengthen the state's focus on serving people with mental health disabilities as a priority. We recommend that the consolidation planning include planning for revenue maximization.

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